A-Z Speech Therapy, Inc.

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RELEASE OF INFORMATION

NAME	DOB
MAIN CONTACT	EMAIL
ADDRESS	CITY, STATE, ZIP
MOBILE PHONE	ALTERNATE PHONE

AUTHORIZATION FOR RELEASE

I, ____ (PATIENT/GUARDIAN NAME), HEREBY AUTHORIZE THE FOLLOWING ENTITY TO RELEASE THE FOLLOWING INFORMATION FROM MY/MY CHILD'S MEDICAL RECORD:

RELEASE INFO TO/FROM-NAME AND ADDRESS	TYPE OF INFO TO BE RELEASED
DATES FROM:	DATES TO:

PURPOSE OF RELEASE

PROVIDER/CLINIC PHONE	PROVIDER/CLINIC FAX

PREFERRED METHOD TO RECEIVE RECORD

PLEASE FAX TO 1(855)756-1854 OR SEND ENCRYPTED EMAIL TO REFERRAL@AZSPEECHTHERAPYAK.COM

TERMS AND CONDITIONS

I UNDERSTAND THAT:
- I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN BASED ON THIS AUTHORIZATION.
- THE INFORMATION DISCLOSED MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS.
- I HAVE THE RIGHT TO INSPECT OR RECEIVE A COPY OF THE INFORMATION TO BE USED OR DISCLOSED, AS PROVIDED BY LAW.
- A PHOTOCOPY OR FAX OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

SIGNATURE	DATE

THIS AUTHORIZATION WILL EXPIRE ON: ____________ (IF NOT SPECIFIED, THIS RELEASE WILL EXPIRE ONE YEAR FROM THE DATE SIGNED).

THANK YOU FROM A-Z SPEECH THERAPY, INC.!